Feld Family Chiropractic Center
126 West Main Street, Rockaway NJ 07866
Information/Application for Care

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT.

Today's Date ____________

Name ________________________________ Home Phone _____________ Work Phone _____________

Cell Phone ____________________ E-Mail Address ____

Address _____________________________________ City __________________ State ___ Zip ______

Age _____ Birth date ____________________ Marital Status: S M W D Number of Children _____

Your Employer ____________________________ Occupation ___________________ Years on Job ____

Employer Address ___________________________ City ___________________ State _____ Zip ______

Insurance Company _________________________ Your Social Security # _____________________________

Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____

Name of Spouse or Parent _________________________________ Their birthdate ______________

Spouse Employed By __________________________ Occupation _________________ Years On Job ____

Employer Address ___________________________ City ___________________ State _____ Zip ______

Office Phone # _________________ Spouse's SS# _______________________

Driver's License # ____________________________________ Referred to our office by: _______________________

Does your spouse have health insurance at work? Yes ____ No ____

How payment will be made: ___ Cash ___Credit Card ___Check

Type of Insurance: ___Health Insurance ___ Worker's Comp. ___Automobile Insurance Policy

Is your condition due to an accident? Yes ___ No ___ Date of accident?____________________

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other ___________________

Have you ever been in an auto accident? Past Year ___Past 5 Years ___Over 5 Years ___Never ____

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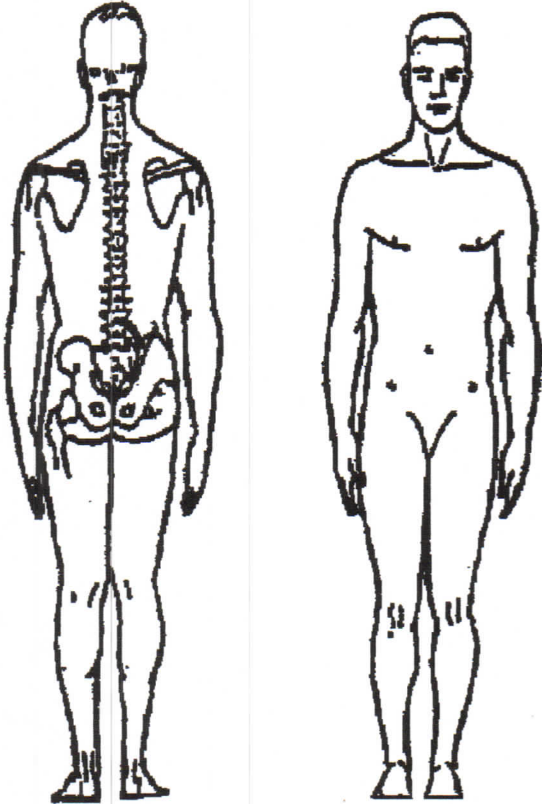
COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.



MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.) ______________________________

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MEDICATIONS

(Please list any medications you are currently taking.)

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I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature ______________________________ Date ____________________
Or Guardian Signature ______________________________ Date ____________________

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.
Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.